Integrating Community Health Program

BANGLADESH COUNTRY SNAPSHOT

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LAST MILE HEALTH

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Acronyms

AHI	Assistant Health Inspector
ANC	Antenatal care
BDT	Bangladeshi Taka
BNHWS	Bangladesh National Health Workforce Strategy
CBHC	Community Based Health Care
CBHS	Community Based Health Services
CBO	Community Based Organization
CC	Community Clinic
CG	Community Groups
CHCP	Community Health Care Provider
CHW	Community Health Worker
CMP	Community Micro-planning
COVID-19	Coronavirus disease 2019
CSBA	Community Skilled Birth Attendant
CSC	Community Score Card
CSG	Community Support Groups
CSO	Civil Society Organization
DCC	District Coordination Committee
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DLL	District Learning Laboratory
DP	Development Partner
DRC	Democratic Republic of Congo
DTP3	Diphtheria-tetanus-pertussis
EPI	Expanded Program on Immunization
ESP	Essential Service Package
FP	Family Planning
FPI	Family Planning Inspectors
FWA	Family Welfare Assistant
FWAI	Family Welfare Assistant Inspector
FYP	Five Year Plan
GOB	Government of Bangladesh
HA	Health Assistant
HAI	Health Assistant Inspector
HI	Health Inspector
HNP	Health, Nutrition and Population
HPNSDP	Health, Population and Nutrition Sector Development Program
HPNSP	Health, Population and Nutrition Sector Program
HPSP	Health and Population Sector Program
HRD	Human Resource Development
ICH	Integrating Community Health

ICHC	Institutionalizing Community Health Conference
ICHW	Improving Community Health Workers
IPC	Infection Prevention and Control
JD	Job description
LD	Line Director
LGD	Local Government Division
LGI	Local Government Institutions
LMH	Last Mile Health
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MNCAH	Maternal, Newborn, Child and Adolescent Health
MNCH	Maternal, Newborn, and Child Health
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MPHV	Multi-Purpose Health Volunteer
NCD	Non-communicable disease
NGO	Non-governmental organization
ICH	Integrating Community Health
INGO	International non-governmental organization
NHWS	National Health Workforce Strategy
NIPORT	National Institute of Population Research and Training
NSC	National Steering Committee
NSF	National Stakeholder Forum
OP	Operational Plan
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PHD	Partners in Health & Development
PPV	Paid Peer Volunteers
RCHCIB	Revitalization of the Community Health Care Initiative in Bangladesh
SCI	Save the Children International
SDG	Sustainable Development Goals
SS	Shasthya Shebika
SWAp	Sector-Wide Approach
TWG	Technical Working Group
UFPO	Upazila Family Planning Officer
UHC	Universal Health Care
UHE&FP	Union Health, Education & Family Planning
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Union Parishad
USAID	United States Agency for International Development
USD	United States Dollars
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Preface

Accelerating the Integration of Community Health Worker Programs through Institutional Reform

Approximately half of the world's population do not have access to essential health services. A growing emphasis on the roles of communities recognizes community engagement, including community health workers (CHWs), as a means of realizing the full potential of the primary healthcare (PHC) system.[1] High performing CHW programs at scale are an integral component of responsive, accessible, equitable, and high-quality PHC.

Recognizing the potential for community health to address gaps in coverage, improve financial protection, and support access to quality care, the Declaration of Astana in 2018 committed to strengthening the role of community health in PHC as a means to accelerate progress toward universal health coverage (UHC). Before the Declaration of Astana, the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) also helped to reposition communities as resources for health systems strengthening and sources of resilience for individuals and families.

The United States Agency for International Development (USAID) initiated a collaboration with the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation in 2016 to advance country commitments toward communities as resources in PHC systems to accelerate progress towards the achievement of the SDGs. The Integrating Community Health (ICH) collaboration fueled a global movement with more than twenty countries to elevate national priorities and progress for institutionalizing community health in primary health care systems. USAID, in collaboration with UNICEF, invested in catalytic partnerships with governments, their trusted NGO partners, and communities across 7 countries (Bangladesh, the Democratic Republic of Congo (DRC), Haiti, Kenya, Liberia, Mali, and Uganda) to institutionalize reforms and learning, with a focus on CHWs. In alignment with these efforts, the Bill & Melinda Gates Foundation supported the development of new evidence and knowledge regarding performance measurement, advocacy and pathways to scale in the seven focal countries via the Frontline Health Project with Population Council and Last Mile Health as lead partners. Using Last Mile Health's Community Health Reform Cycle framework, the Country Snapshots highlight the ICH collaboration's catalytic partnerships to strengthen national CHW programs as an essential component of PHC and to place these programs within the context of institutional reforms and political commitment needed for national progress in health outcomes.

Re-envisioning health systems to achieve UHC requires leadership and political commitment from within countries. Countries must mobilize the whole society—both public and private sectors as well as communities—as essential resources in this effort. The community component of PHC must be designed to enable the health system to reach the most underserved, respond to pandemics, close the child survival gap, and accelerate the transformation of health systems. Without a major expansion of support for national CHW programs, the measurable acceleration urgently needed to reach the health-related targets of the SDGs by 2030 is unlikely. With a decade remaining to achieve the SDGs and faced with the challenge of the COVID-19 response, building global political momentum with countries and funders is critical to support urgent national priorities, evaluate progress, and develop and share new knowledge to inform bold political choices for a whole of society approach to health systems strengthening.

Community Health Institutionalization as a "Reform Cycle"

The Country Snapshots featured in this series highlight the seven ICH countries' reform efforts within a framework for institutional reform: the Community Health Systems Reform Cycle (often referred to here as the "reform cycle").[2] Countries experience community health systems reform as a process and pathway to institutionalizing community health. The likelihood that any particular reform is successfully institutionalized in an existing policy environment depends on political will and buy-in from key stakeholders, the technical design of the policy, the available capacity and resources to launch and govern the intervention, the ability to learn, and the willingness to adapt and improve the program over time.

The reform cycle framework has guided—and been refined through—a descriptive analysis of the ICH countries' reform journeys. Country Snapshots, reflecting the ICH investment on community health systems reform, demonstrate the practical linkages between available literature and specific country experiences. This framework provides health systems leaders with an approach to plan, assess, and strengthen the institutional reforms necessary to prioritize community health worker programs as part of national primary health care strategies to achieve universal health coverage.

The reform cycle traces several stages of institutional reform, which are summarized below. Reforms may encompass an entire community health worker program or target specific systems components, such as health information systems. While reforms may not always follow each stage in sequence and timing can vary depending on the complexity of the program or activity, deliberate and comprehensive planning can strengthen buy-in and overall effectiveness.

THE COMMUNITY HEALTH SYSTEMS **REFORM CYCLE**

PROBLEM PRIORITIZATION

Actors identify a meaningful and relevant problem. They diagnose pain points and unmet needs, and connect them to priority areas for reform, where possible. Actors acknowledge the need for reform within the community health system and commit to a joint vision for addressing gaps.

COALITION BUILDING

A group is formed around a compelling problem or vision. Members define the coalition's goals, roles, size, and composition. Diverse members fill critical roles in the reform effort (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).

SOLUTION GATHERING

Potential solutions are gathered, drawing from existing local and international programs. Actors define criteria and metrics to assess solutions, and specific ideas for reform are piloted, where possible. Promising solutions are prioritized for integration into the health system.

DESIGN

Key decision makers, stakeholders, and planners map out different options for program design. Where possible, evidence about the options, expected cost, impact, and feasibility are identified. Through consultations, workshops, and other channels, stakeholders offer feedback on options, and decision makers select a design. This may include operational plans, training materials, job descriptions, management tools, data collection systems, and supply chain processes.

READINESS

Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program. Stakeholders also translate program design into costed operational plans that include clear strategies and tools for launch and rollout. Investment plans for sustainable financing and funding mechanisms are put in place. Stakeholders are prepared for their new roles and responsibilities, and potential areas of policy/protocol conflicts are addressed.

LAUNCH

New policies, processes, and organizational structures are implemented, and key actors execute their new roles. As these shifts progress, learning is gathered to demonstrate momentum and identify challenges to achieving scale. Particular attention is paid to issues around rollout, and timely design and implementation shifts are made as needed.

GOVERNANCE

Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights. Processes for risk and issue management, stakeholder engagement, and cross-functional communication are established. Actors monitor program progress to advance clear decision-making and address critical issues or challenges.

MANAGEMENT & LEARNING

Key stakeholders regularly review program data to inform problem-solving at the national or subnational level. Stakeholders engage in continuous learning and improvement, identifying challenges and changes to program design and other systems bottlenecks.

Country Snapshots of Institutional Reform

PURPOSE AND GOALS OF COUNTRY SNAPSHOTS

- Describe the community health landscape within each country
- Present the country's vision for community health reform and situate progress to-date within the framework of the reform cycle
- Articulate the primary community health institutionalization challenges that the country is or was facing at the outset of the ICH investment
- Trace the policy and advocacy process taken by country stakeholders to move reform forward, using the ICH investment as a catalyst
- Identify lessons learned and opportunities for strengthening existing reforms arising out of the ICH investment

The Country Snapshots complement other resources generated within and beyond the ICH investment, such as the countries' Community Health Acceleration Roadmaps, ICH Country Case Studies, and Frontline Health Project Research Studies. The Country Snapshots place a unique emphasis on tracing the process of policy choice, advocacy, and implementation. Together, these complementary initiatives are catalyzing community health systems reform and advancing efforts towards a strong primary health care system and UHC.

APPROACH AND METHODS

The Country Snapshots highlight examples of a country's reform journey through the specific stages of institutionalization outlined in the framework. Country Snapshots both demonstrate the features of each stage within the country context and elevate salient examples of countries' learning and success. The Country Snapshots reflect a process of desk reviews and consultations with country stakeholders. Stakeholders include but are not limited to current and former Ministry of Health representatives, leaders from non-governmental and technical organizations, and members of multilateral and bilateral institutions. The Country Snapshots elevate both existing insights captured in policy and strategy documents that are often difficult for those not working within the country to access, as well as novel perspectives gained through methods such as workshops or in-depth interviews with key stakeholders. Where the Country Snapshots draw on existing materials, citations are noted. Insights and country stakeholder recommendations on the reform cycle's application serve not only to validate the framework, but also to highlight ways in which the framework can help trace powerful narratives of reform and accelerate community health systems policy and advocacy efforts.

These narratives reveal opportunities to accelerate the prioritization of community health worker programs and primary health care strategies with the goal of UHC. The Country Snapshots reflect valuable feedback from stakeholders on how the framework can help advance community health systems policy and advocacy.

Key Resources

- USAID Vision for Health Systems Strengthening 2030
- Astana Declaration
- CHW Resolution
- CHW Guidelines
- Exemplars—Community Health Workers
- Community Health Roadmap
- Institutionalizing Community Health Conference 2017
- Institutionalizing Community Health Conference 2021
- Community Health Community of Practice
- Global Health: Science and Practice Supplement 1: March 2021
- Journal of Global Health: Advancing Community Health Measurement, Policy and Practice

Synopsis

Over the last five years, Bangladesh advanced through the last two stages of the Community Health Systems Reform Cycle and laid the foundation of a new reform cycle. The country has a long history of using community health workers as a key resource to achieve national health and family planning priorities since the 1970s and 1980s. Bangladesh also had a prolonged national rollout of a Community Based Health Care program with robust operational plans from 1998 to 2016.[i] More recently, the country turned its focus to improving program governance and management to support ongoing implementation, as well as using learning to refine program performance. Building on previous country experience and successes—and leveraging its pluralistic health sector environment—Bangladesh quickly stepped forward into the first four stages of a new Community Health Systems Reform Cycle, setting the groundwork for problem prioritization, coalition building, solution gathering, and policy and program design—and paving the road to further advance the unfinished community health systems institutionalization agenda.

i. Initially introduced as the Community Based Healthcare (CBHC) program from 1998 to 2003, then re-prioritized through the project "Revitalization of the Community Health Care Initiative in Bangladesh" (RCHCIB), 2009-2016.

Bangladesh's Community Health Policy and Advocacy Landscape

Health Access and Outcomes in Bangladesh

Since its independence in 1971, Bangladesh has steadily achieved remarkable progress in health outcomes despite having low levels of health spending compared to its neighboring countries—and one of the lowest levels of human resources for health in the world. Between 1990 and 2015, Bangladesh achieved most of the health-related Millennium Development Goals (MDGs) by reducing neonatal mortality by 65%, and under-five, infant, and maternal mortality rates by over 70%.[3] Today, Bangladesh has one of the longest life expectancies, lowest total fertility rates, and lowest under-five mortality rates in South Asia.[4]

Community health workers (CHWs) have been central to achieving these results. Over the last five decades, Bangladesh has relied on a wide range of community-level interventions delivered by CHWs to respond to the country's health needs. This includes family planning, immunization efforts, and diarrheal disease control programs. At least in part due to the CHWs involvement, the contraceptive prevalence rate among rural women has increased by a factor of 10 from the 1970s to date, and the portion of rural children who receive the diphtheria-pertussis-tetanus 3 (DTP3) vaccine has increased from near zero to more than 90% from the 1980s to date.[4]

Bangladesh has also relied on a pluralistic health system—with government, private, and non-governmental organization (NGO) providers—to deliver community- and facility-based health services to its population. Both the pluralistic approach to health and CHW programming are considered important factors in the country's improving health outcomes.[4,5] Currently, Bangladesh has over 185,000 CHWs, with diverse scopes of work and profiles, delivering health services across the country. (See Appendix 1 for more detail.) About 70,000 CHWs work for the government, 50,000 work for the NGO BRAC, and the remainder work for other NGOs and the private sector.[5]

INDICATOR [DEMOGRAPHIC HEALTH SURVEY] *	1993-94	1996-97	1999-00	2004	2007	2011	2014	2017-18
Infant Mortality Rate (per 1,000 live births)	87	82	66	65	52	43	38	38
Under-Five Mortality Rate (per 1,000 live births)	133	116	94	88	65	53	46	45
Maternal Mortality Ratio (per 100,000 live births)	470	-	322	-	-	194	-	196
Children Completely Vaccinated (%)	59	54	60	73	82	86	84	89
Children with Diarrhea Treated with ORS (%)	50	48	61	67	81	81	84	85
Unmet Need for FP Among Married Women (%)	19	16	15	11	17	14	12	12
Delivery with Skilled Personnel (%)	10	8	12	16	21	32	42	53
ANC 4+ (%)	6	6	11	17	22	26	31	47

* Maternal Mortality Ratios are from Bangladesh Maternal Mortality and Health Care Survey (BMMS) 2001, 2010, and 2016.

Today, Bangladesh faces new challenges, such as growing urbanization of the population, rising prevalence of noncommunicable diseases, and the recent influx of Rohingya refugees in Cox's Bazar District. The country also continues to address gaps in health quality and access, such as disparities between rural and urban areas, and high out-of-pocket expenditures. Addressing these challenges will require the country to show continued commitment to innovation and adaptation of its health workforce.

Bangladesh's Community Health Reform Foundations

EARLY HISTORY OF COMMUNITY HEALTH WORKER PROGRAMMING

The right to health is enshrined in Bangladesh's Constitution, which states that it is the fundamental responsibility of the state to ensure health services for its citizens.[6] Bangladesh's Ministry of Health and Family Welfare (MOHFW) is the authority responsible for formulating national-level policy and planning, and regulating the health sector. Within the MOHFW, two main implementing authorities execute the health policy: the Directorate General of Family Planning (DGFP) and the Directorate General of Health Services (DGHS).

Following independence in 1971, development partners (DPs) played an important role in supporting the Government of Bangladesh (GOB) by financing a series of projects separately focused on family planning (FP) and health. Major policies and programs during the 1970s and 1980s focused on delivering core FP planning, and maternal and child health (MCH) services to the rural population through primary- and secondary-level facilities and CHWs.[7]

In 1976, the government recruited 13,500 full-time CHWs, known as Family Welfare Assistants (FWAs), to support the recently launched National Family Planning Program. The main goal of the program was to decrease high fertility rates in the country—a goal that was seen as a critical step to achieving economic self-sufficiency after independence. Over the next fifteen years, the government expanded FWAs' focus beyond family planning to support immunization and other MCH services, and also increased the number of FWAs. By 1991, 23,500 FWAs from the DGFP were providing health services through domiciliary (home) visits, and they were supported by satellite clinics for family planning distribution.[4]

While the government launched its first FWAs, NGOs began experimenting with their own CHW cadres to address national priorities identified by the government. During the 1980s, the government partnered with BRAC and CARE to train their own CHWs to mobilize support for immunization campaigns in regions where government CHWs were not yet firmly established. In 1990, BRAC formally introduced the Shasthya Shebika (SS), a volunteer cadre that evolved from its 1970s experience.[4]

In 1991, the government formalized the introduction of a new CHW cadre, known as Health Assistants (HAs), to support its Expanded Program on Immunization (EPI) through domiciliary visits and community outreach. HAs were recruited by the DGHS, and like FWAs, progressively expanded their focus to provide additional services. FWAs and HAs reflected the bifurcated nature of Bangladesh's MOHFW. Each cadre was sponsored by a separate directorate, each managing their own health facilities and staff, and maintaining their own supervision, training, referral mechanisms, and health information systems.[4]

INTRODUCTION OF THE SECTOR-WIDE APPROACH,1998

Bangladesh embarked on a major health sector reform in 1998, aiming to increase efficiency, sustainability, and integration of the existing health system and services.[7] The MOHFW and its partners moved away from a project-based modality and introduced a Sector-Wide Approach (SWAp) for health programming. With this approach, the government led the implementation of a single Health and Population Sector Program through operational plans, each led by a Line Director (LD). Every operational plan included a set of SWAp activities, outlined in strategic plans, along with

budgets, and periodic reviews of performance and resources led by the MOHFW.[7] Resources came from government revenue and development partners' pooled and bilateral funding, channeled through on-budget financing.

The main focus of the first SWAp—the Health and Population Sector Program (HPSP 1998–2003)—was to decentralize the delivery of an Essential Service Package (ESP) using a 'one-stop' service model to deliver basic health and FP services to rural communities from clinics located at the community level. Notably, the HPSP earmarked 60% of the health budget to the provision of the ESP. Since then, the MOHFW has implemented three consecutive SWAp programs and is currently implementing a fourth. The overarching goal of all SWAps has been to improve access to and utilization of an essential package of health, population, and nutrition services, particularly by vulnerable groups, including women and children.[7]

Although SWAps are designed with the entire health sector in mind, there are other health activities implemented within the health sector that do not fall under the SWAp. This includes the health interventions implemented outside the MOHFW (e.g., the urban health program of the Ministry of Local Government) and the health programs implemented by NGOs or the private sector.[7]

LAUNCH OF THE COMMUNITY BASED HEALTH CARE PROGRAM, 1998-2001

In 1998, per initiative of Prime Minister Sheikh Hasina, Bangladesh launched the Community Based Health Care (CBHC) program through the first SWAp, the HPSP. The CBHC program introduced the Community Clinic (CC) concept "to extend quality primary healthcare services to the doorsteps of rural people all over the country."[8] The objective was to ensure access and utilization of the ESP at the community level through the CC. The plan was to establish 13,500 CCs—one for every 6,000-10,000 population—and existing FWAs and HAs would provide services from the new clinics.

To implement the CBHC program, the MOHFW established the CC project within the DGHS. From 1998 to 2001, community engagement and clinic construction began on community-donated land. The DGHS constructed 10,723 CCs and about 8,000 started functioning.[8] However, in 2001 the new national government withdrew support for and halted the CC program due to a shift in priorities.

REVITALIZATION OF THE COMMUNITY HEALTH CARE INITIATIVE, 2009-2016

In 2009, with the return of Prime Minister Sheikh Hasina to the national government, the MOHFW reprioritized the CBHC program through an initiative called Revitalization of the Community Health Care Initiative in Bangladesh (RCHCIB, 2009-2016). The initiative introduced a new CHW cadre, the Community Health Care Provider (CHCP), to be permanently based at the CC. Each CC would act as a hub for CHWs to provide services to the community. FWAs and HAs, who traditionally focused on delivering domiciliary family planning and EPI services, would now spend half of their time at the CC supporting the services provided by the CHCP.

SECTOR-WIDE APPROACH (SWAP) IN BANGLADESH: TITLES AND MAIN OBJECTIVES/FOCUS

- Health and Population Sector Program (HPSP) 1998-2003: decentralize the provision of the ESP using a 'one-stop' service model to deliver basic health and FP services to rural communities from CC
- Health, Population and Nutrition Sector Program (HPNSP) 2003-2011: increase the availability and utilization of user-centered, effective, efficient, equitable, affordable, and accessible quality HNP services
- Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016: strengthen health systems and improve health and FP services
- Health, Population and Nutrition Sector Program (HPNSP) 2017-2022: improve equity, quality, and efficiency with a view to moving gradually towards UHC and achieving health related SDGs

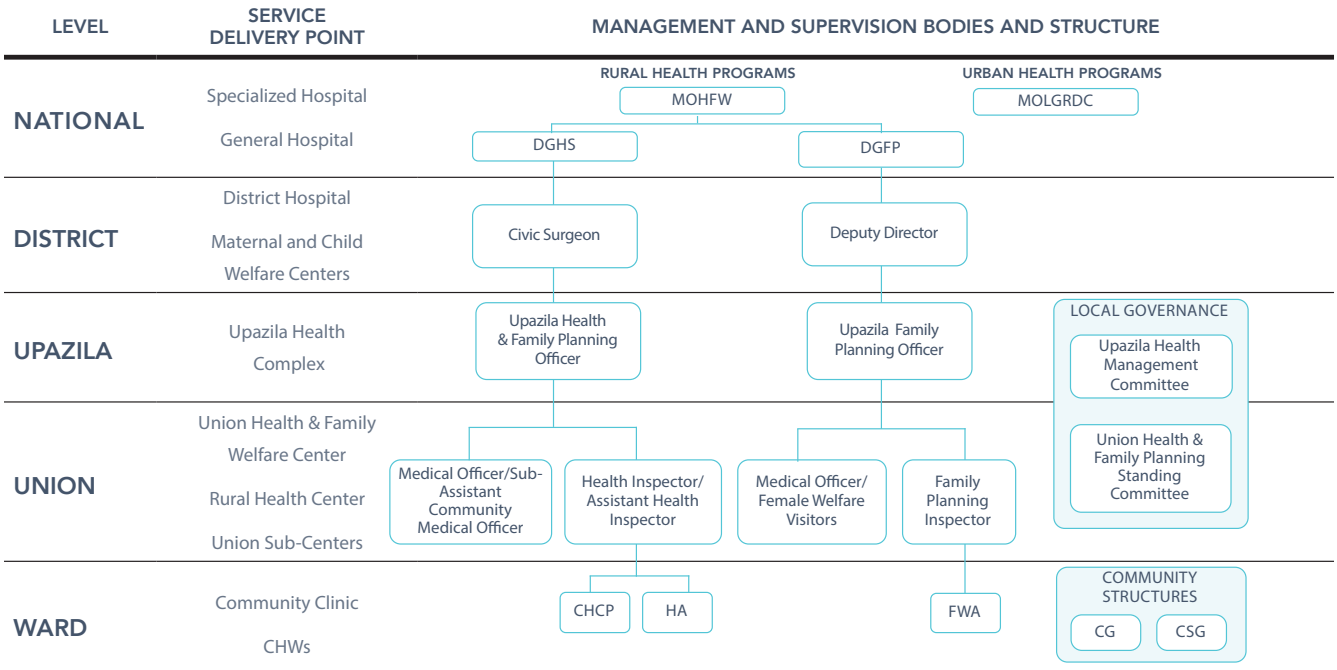
The RCHCIB initiative aimed to strengthen community and local government engagement in the provision of health services through a public-private partnership with the community. First, the government constructs the CC on community-donated land and covers the costs of service providers, medicines, and equipment. Then, Community Groups (CG) and Community Support Groups (CSG) provide management and oversight support to the CC, and mobilize local resources to support management of the CC.

The initiative was originally implemented as a separate project of the MOHFW outside the Health Sector Program, generating funding instability and implementation challenges until 2011, when the program was operationalized in the third SWAp, the Health, Population, and Nutrition Sector Development Program (HPNSDP, 2011-2016). The DGHS appointed an LD to lead the implementation of the CBHC Operational Plan (CBHC OP), which was now backed by a functional administrative structure with staff, budget, and infrastructure.

In 2012, Bangladesh ramped up the rollout of the CBHC program. In the next six years, the GOB finalized the construction of 13,779 CCs and staffed them with 13,507 CHCPs, 19,583 FWAs, and 15,420 HAs.[5,6] Government budget allocations, primarily for medicines and CHCPs' salaries, almost doubled between 2012 and 2018, reaching a recurrent budget of 6,374 million BDT (75 million USD) for the fiscal year 2017-2018.[8]

Today, the CC is envisioned as a core element of Bangladesh's primary healthcare system and as a flagship program of the current administration. The CC is the lowest fixed-facility tier of the Upazila (sub-district) Health System. (See Appendix 2 for more detail). CCs refer patients to Union Health and Family Welfare Centres (UH&FWCs) at the Union level, and the Upazila Health Complex at the Upazila level. Assistant Health Inspectors (AHI) from Union level and Health Inspectors (HI) from the Upazila level (DGHS) supervise HAs and CHCPs. Family Planning Inspectors (FPI) from the Union level (DGFP) supervise FWAs. Upazila Health and Family Planning Officers (UH&FPO) and Upazila Family Planning Officers (UFPO) are the managers at the sub-district level, and the Civil Surgeon is the overall manager at the District level.

The local government—Union Parishad (UP)—is engaged in the monitoring and management of the CC through the Union Health, Education & Family Planning (UHE&FP) Standing Committee, the local body responsible for overseeing health and family planning functions at the Union level. The UP chair is the overall patron of CCs at the local level, and UP members chair CGs and CSGs. The CHCP acts as secretary of the CG.



The Institutionalization Challenge In Bangladesh

Bangladesh in the Community Health Systems Reform Cycle

STRENGTHENING GOVERNANCE AND MANAGEMENT IN BANGLADESH'S HEALTH SECTOR

The Community Health Systems Reform Cycle provides a useful framework for analyzing Bangladesh's community health systems reform journey, which mirrors the country's health sector reform journey. The reform cycle provides insights into the foundations, strategies, and challenges of the reform process.

Prior to 2016, Bangladesh experienced various, often overlapping reform cycles that laid the foundations of the country's community health system. Starting in 1998, the CBHC program embarked on its own reform cycle, identifying priority areas for reform, designing new policies, and mobilizing resources to support the ongoing implementation of the program.

In 2016, Bangladesh had nearly completed the national rollout of the CBHC program. Across the country, the government and its partners supported the ongoing implementation of the program, enforcing adherence to standards, addressing performance gaps, and strengthening overall program governance and management. Learnings from community health programming were setting the stage for upcoming program refinement as the CBHC revitalization initiative wrapped up and the fourth Health, Population, and Nutrition Sector Program (HPNSP, 2017-2022) was being developed.

At the same time, the MOHFW launched its National Health Workforce Strategy (BNHWS, 2016-2021), following Bangladesh's seventh Five Year Plan (FYP) and its strategic guideline to "improve governance and management in the health sector."[9] The strategy provided a framework to address priority health workforce management challenges, focusing on five key areas: health workforce planning, capacity building, deployment, managing high performance, and information systems.

The fourth HPNSP was developed with the vision of building upon previous successes to improve equity, quality, and efficiency—moving gradually toward UHC and health-related Sustainable Development Goals (SDGs). The fourth HPNSP laid out eight strategic objectives categorized under three main components: 1) Governance and stewardship, 2) HNP system's strengthening, and 3) Provision of quality HNP services.[6]

The fourth HPNSP also reinforced the country's commitment to the vision of the CC as the basic unit of the primary healthcare system through a new CBHC Operational Plan and extended the scope of the CBHC program to include the provision of essential health services from all Upazila health facilities.[10] With this, the program aimed to strengthen health system integration across community, Upazila, and district levels.

PROGRAM LEARNING AND IDENTIFICATION OF PERFORMANCE GAPS IN COMMUNITY-BASED HEALTH SERVICES

In early 2018, WHO Bangladesh and the DGHS commissioned an independent evaluation of the CBHC program to assess its contribution to the effective delivery of primary healthcare services, and to identify its strengths and challenges regarding the successful implementation of the ESP. As stated by the President of the Community

Clinic Health Support Trustee Board in the evaluation report:

> *"The CBHC initiative now seeks to improve the quality of services and its closer alignment with the strategic directions of the health sector in order to establish a more effective and sustainable 'one stop' service outlet for the community people of Bangladesh."*[8]

STRENGTHS IDENTIFIED

The evaluation conducted a document review that highlighted program learnings throughout the implementation of the CBHC program. The evaluation found that Bangladesh has made important progress in program implementation. The evaluation recognized that the design is relevant to the health needs of the population and has potential to broaden the scope of services to respond to emerging health needs and achieve SDGs and UHC. It also noted that CHWs have been essential to delivering the ESP at the community level, and to increasing access and utilization of services through the years.

OPPORTUNITIES IDENTIFIED

However, the evaluation found that numerous constraints had led to inefficient operations of the program and that implementation of the CBHC policy had yet to achieve its full potential. Constraints included the inadequate mix and scope of services currently provided given the evolving population profile, limited human resources, discontinuity in services, gaps in logistics, insufficient support roles, suboptimal organization of community engagement, and poor coordination between CHW cadres (largely due to parallel DGFP and DGHS management structures).[8]

Institutionalization Challenges in Bangladesh

Performance gaps identified in community-based health services reflected broader challenges in Bangladesh's health sector—particularly in governance and management—that affected community health programming since its inception.

The GOB introduced CHW cadres to address different challenges at different times, and reforms were often led by different government actors. Broader health workforce planning and decision-making was (and still is) done in a separate division of the MOHFW, with limited coordination with divisions responsible for CHWs. Stakeholders did not always have the same perspective on priority areas for reform or a joint vision for addressing gaps. As a result, different community health reform efforts advanced without a common plan or coordination. Over time, a variety of structures and institutions emerged, which led to fragmented program design, financing, implementation, governance, and management approaches. This fragmentation eventually led to performance gaps when programs overlapped.

PERSISTENT INSTITUTIONALIZED FRAGMENTATION OF THE HEALTH SYSTEM

The bifurcated nature of the MOHFW between the Health Services and Family Planning divisions has persisted for decades and is deeply institutionalized within the health system structure. The DGHS and DGFP each manage their own health facilities and staff, and they maintain their own supervision, training, referral mechanisms, and health information systems. Furthermore, urban primary healthcare is the responsibility of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC), and is carried out through the city corporations and municipalities.[6] This fragmented structure replicates across all the health system tiers from national to community level.

At the community level, insufficient coordination and integration of activities undermine the effective provision of services. CHCPs, FWAs, and HAs have roles that are sometimes complementary or overlapping, and they often lack the appropriate forums and tools for coordination. Job descriptions, training, and supervision systems are often not aligned, which poses challenges for a harmonized and integrated service delivery of the ESP at the community level. Job descriptions of HAs and FWAs do not include work at the CC, thus are not fully aligned with the CC concept.[8]

Refresher trainings often respond to vertical program needs instead of aligning to the specific training needs and skills of staff at the CC. Supervision is conducted by various cadres, using standard checklists. The seventh FYP stressed this challenge: "Guidance jointly issued by the DGHS and DGFP for field level coordination and supervision needs better compliance for turning the CC into an effective first service contact."[9]

In addition to challenges with government CHWs, the various NGO cadres have not, among themselves, coordinated the delivery of health services by geography, patient type, or service type. Moreover, NGOs have not always concentrated their efforts in areas underserved by the government cadres,[4] nor coordinated effectively with the government around the CC model.

SUBOPTIMAL LOCAL GOVERNANCE AND MANAGEMENT, AND COMMUNITY ENGAGEMENT

Community Clinics perform better when there are well functioning CGs and CSGs. Evidence suggests that active participation of members of the Union Parishad (UP)—the local government—as chairs of CGs facilitates strong performance of CGs; and, in turn, a well-functioning CG makes CC health workers more accountable.[8]

However, most CGs and CSGs do not meet regularly, have workplans, or have mechanisms for routine monitoring and evaluation. Members do not always have clarity on their roles, and their ability to provide management support to the CC is constrained by the availability of funds (e.g., to pay cleaners, guards, and electricity bills). Members don't always have good relationships with the Upazila and NGOs, which usually helps with access to additional resources.[8]

UPs are supposed to provide 15% of their total budget to the implementation of health and family planning programs, including the overall monitoring and management of the CC. However, UP members change every two years, often leading to gaps in the involvement of new members. UP members commonly describe not being aware of their official roles and responsibilities and not participating in CGs meetings. UHE&FP Standing Committees are often inactive and do not allocate funds to CC management.[8,11]

LIMITED INCENTIVES AND MECHANISMS FOR HEALTH SECTOR COORDINATION

The introduction of SWAps for health sector policy and planning initially created an atmosphere for better coordination, harmonization, and alignment of DP-funded projects, which strengthened MOHFW's role in sector coordination and management over time.[7] However, the structure of HNP programs under the SWAp still promotes vertical operational plans with their own budgets and management structures that tend to fragment service delivery.

Under SWAps, all significant funding for the sector supports a single policy and expenditure program. However, project aid to SWAps does not pay for MOHFW staff salaries. These remain under GOB revenue budget. Over the years, this caveat allowed the MOHFW to have parallel projects and development activities implemented by non-state actors outside the SWAp, which further exacerbated fragmentation.

One of the major institutional reforms tried under the first SWAp was the integration of health and family planning services provided by the DGHS and DGFP. However, this reform was not continuously pursued[7] and, upon review in 2003, the government decided to reestablish separate organizational structures and authorities, as they had existed before 1998.

Ultimately, given the persistent fragmentation of the health system at all levels, every step in the reform cycle process challenges the status quo as well as spheres of political and economic influence that have been reinforced for decades. As a result, there have been significant institutionalization challenges across each stage of the reform cycle.

ICH Investment as a Catalyst for Reform

Objectives of the ICH Investment in Bangladesh

In March 2016, Save the Children Bangladesh, supported by USAID's Global Health Bureau in collaboration with UNICEF, launched the Improving Community Health Workers (ICHW) project. The goal of ICHW was to support the Government of Bangladesh in improving the performance of CHW programs and achieving effective coverage of high-impact health and nutrition interventions at scale.

The ICHW project had two overall goals:

- Strengthen existing national policies, systems, and implementation mechanisms related to CHWs by addressing major program performance barriers
- Facilitate systems change and catalyze the institutionalization of Bangladesh's community health system by leveraging project learnings and facilitating stakeholder forums and consensus at all levels

The ICHW investment had three objectives across the domains of institutionalization of CHWs, measurement to influence systems and policies, and inclusive and effective partnerships:

1. Establish efficient and effective linkages between communities, health services, and local systems
2. Generate and use evidence and data for decision making to promote scale, equity, and mutual accountability at all levels
3. Improve coordination and collaboration between government, civil society, and the private sector to influence national and local policies and plans

BANGLADESH'S ICH INVESTMENT AT A GLANCE

PROJECT: Improving Community Health Workers Program Performances through Harmonization and Community Engagement to Sustain Effective Coverage at Scale in Bangladesh. Commonly known as the Improving Community Health Workers (ICHW) project.

IMPLEMENTING PARTNER: Prime: Save the Children Bangladesh; Sub: Partners in Health & Development (PHD)

DATES: March 18, 2016 – March 17, 2020 Amount: 2,000,000 USD (USAID), 500,000 USD (Cost Share), 2,000,000 USD (Leverage)

OBJECTIVES:

1. Institutionalization of CHWs: Establish efficient and effective linkages between communities, health services, and local systems, inclusive of change in behavior that reduce gender barriers in systems and social norms
2. Measurement to influence systems and policies: Generate and use evidence and data for decision making to promote scale, equity, and mutual accountability at all levels
3. Inclusive and effective partnerships: Improve coordination and collaboration between government, civil society, and the private sector to influence national and local policies and plans

GEOGRAPHIC FOCUS:

- National policy, advocacy, and coordination
- District learning lab established in six Upazilas of Barisal district: Barisal Sadar, Banaripara, Bakergonj, Babugonj, Wazirpur, and Gournadi

SCALE: Across six Upazilas, and a total of 25 CCs, the project reformed 25 CGs and 75 CSGs, and trained 125 CHWs and first line supervisors.

Following these objectives, the ICHW project expected to achieve three main outcomes:

1. To develop a Community Health Workers Strategy in line with the National Health Workforce Strategy 2015
2. To mainstream CHW and community engagement plans into a national sector M&E framework
3. To concentrate multi-stakeholder efforts, making them functional at various levels

The project defined two main strategic activities to achieve its goals:

1. Establish a district learning laboratory (DLL), focused on supporting effective program implementation and testing innovations
2. Convene multi-stakeholder platforms at the national and local levels to facilitate sharing of program learnings and coordination, and enable dialogue and consensus building

Creating a District Learning Laboratory as a Program Learning and Refinement Hub

In mid-2016, the ICHW project supported the district of Barisal to establish a DLL in six Upazilas with two objectives. First, the project aimed to define and demonstrate the health system changes required to strengthen community and local government engagement. Second, it planned to implement, test, and refine conceptual and system innovations to enhance CHW program efficiency.

The DLL learning agenda and test areas focused on three key enabling factors of community health systems' performance in Bangladesh: harmonization and coordination of CHWs, community engagement, and local government support for CHWs.

The DLL aimed to contribute to Bangladesh's community health learning agenda and address major performance barriers at a national scale by informing the CHW Strategy development process and thus strengthening national policies and systems.

From a policy and advocacy perspective, two design features were key to achieving Barisal's DLL goals. First, the DLL was grounded within the existing systems and policies: the CBHC program and the CC—the flagship government initiative—as the main coordination and innovation hub for various cadres of CHWs. Second, the DLL initiatives addressed barriers that were previously identified and prioritized in the broader health policy agenda. For example, broader health workforce management challenges had been identified in the National Health Workforce Strategy (NHWS). By building on previous consensus, these features facilitated and accelerated stakeholder alignment in Bangladesh's pluralistic environment.

STRENGTHENING COMMUNITY ENGAGEMENT AND LOCAL GOVERNMENT SUPPORT

A DLL baseline evaluation showed that existing community and local government structures involved in monitoring and supporting CHWs and the CC were not fully functional. UP members commonly described not being aware of their official roles and responsibilities and UHE&FP Standing Committees were often inactive. CGs and CSGs were not formed according to MOHFW guidelines and did not meet regularly, resulting in weak monitoring, accountability, and support to CHWs and the CC.[11]

ELEMENTS OF THE CC-CENTERED HEALTH SERVICE MODEL

- CHW harmonization and coordination
- Effective community engagement
- Strengthen local government support
- Monitoring and supervision
- Data analysis and action planning

To strengthen community engagement and local government support, the DLL activated existing structures, oriented their members on their roles and responsibilities, and engaged them in regular and new monitoring and supervision activities. This

approach enabled UP members, CGs, and CSGs to be more involved in CC oversight. This approach also enhanced accountability and resource mobilization, which in turn, contributed to the improvement of service delivery at the community level.[ii]

ACTIVATION AND ENGAGEMENT OF UHE&FP STANDING COMMITTEES

The DLL activated the latent UHE&FP Standing Committees by reaching out to its members (through their respective UP Chairman) and orienting them on their official responsibilities regarding oversight of the CC. The project made the UHE&FP Standing Committees functional by ensuring that bi-monthly meetings were held and actively engaging them in other project activities, such as the reformation of CGs and CSGs, and the facilitation of the Community Score Card, a new accountability tool (described in more detail in next section).

Through these interventions, UP members became increasingly engaged in routine oversight of community health services and UP budget allocations rose, resulting in visible structural improvements to CCs (e.g., better road access, lighting, roofing, and equipment) and an increase in utilization of services.[12]

REFORMATION OF CG AND CSG FOR EFFECTIVE COMMUNITY ENGAGEMENT

Project areas conducted a community mapping exercise and reconfigured membership of CG and CSG to ensure diverse representation from households across all the CC catchment area, instead of only those in close proximity to the CC.

Once reformed, CG and CSG members were trained in CC management and community mobilization and were encouraged to participate in monthly Community Micro-planning (CMP) meetings—joint work planning meetings between CHWs, and their management structures (described in more detail in next section). These interventions enabled CGs and CSGs to increase routine oversight, liaise with community members to share information and promote available services, and mobilize local resources for clinic improvements.

TESTING INNOVATIONS: THE CC CENTERED HEALTH SERVICE MODEL AS A HARMONIZATION AND COORDINATION HUB

Previous evaluations of community-based health services in Bangladesh had identified that the lack of coordination among health, family planning, and NGO CHWs hindered effective program implementation at the community level.[8,9,11] Additionally, insufficient continuous support from the local government and the community acted as barriers for adequate coverage and quality health services.

To address these challenges, the ICHW project designed a coordination and harmonization mechanism among CHWs, in conjunction with strengthened local government support and community engagement. ICHW tested the mechanism at the DLL as the CC Centered Health Service Model from October 2018 to September 2019. The model aimed to provide a more coherent and organized approach to CHW programs leading to increased coverage, improved care-seeking, and increased referrals to higher levels of care.

The core elements of the model consisted of team building and harmonization of CHW roles and responsibilities, engagement of local government officials and the community, development of action plans based on consultation, data collection and analysis, and enhanced supervision and monitoring. To achieve these goals, the model implemented new tools—namely, a harmonized job description (JD) for CHWs, CMP meetings, and a Community Score Card (CSC)—and coupled them with training and capacity building activities.[iii]

CHW HARMONIZATION AND COORDINATION

The ICHW project facilitated the development of a harmonized JD for CHWs and implemented it at the DLL. The harmonized JD consists of a structured, yet flexible, template that outlines the main functions and tasks of all CHW cadres, and the specific ways in which CHWs operating within the same catchment area should coordinate. The harmonized JD was designed to enable different cadres of CHWs to organize their work in a

[ii] For greater detail on the activities implemented at the DLL and their results, see: Save the Children. Strengthening Community Engagement and Local Government Support for Improving Community Health Care Programs. USAID and Save the Children; 2020.

[iii] For greater detail on the activities implemented at the DLL and their results, see: Save the Children. Strengthening Community Health Systems through CHW Harmonization in Bangladesh. USAID and Save the Children; 2020.

complementary fashion and to facilitate alignment of CHW activities across the health system.

In line with CHW harmonization and through the National Institute of Population Research and Training (NIPORT), the project also developed a team training model and curriculum for all CHW cadres, which emphasized team building, joint planning, interpersonal communication skills, and local government engagement. At the DLL, CHWs and their supervisors received the team training and were oriented on how the newly harmonized JD would support them in implementing a coordinated work plan, organize, and conduct monthly joint planning, and report sharing meetings at the CCs. CGs and CSGs were also oriented on how to best contribute to monthly joint planning and report sharing meetings.

COMMUNITY MICRO-PLANNING MEETINGS

The ICHW project introduced monthly CMP meetings to be held together with the already existing Expanded Program on Immunization (EPI) sessions to increase sustainability. Micro-planning meetings were initially adopted by the MaMoni project and were adapted for implementation at the DLL, given its success in increasing community engagement and harmonization among CHW cadres.

Ongoing today, CMP meetings gather CHWs, their supervisors, UP representatives, and representatives from CG/CSG to share information about the target population in the CC catchment area (e.g., newlywed couples, pregnant women, or births and deaths), and to discuss and agree upon activities and coverage priorities for the coming month. Through these routine interactions, CHWs prepare a joint work plan—ensuring full coverage of the catchment area—and align data in their monthly reports, which are then submitted through separate systems to the DGHS, DGFP, and NGO partners.

To increase effectiveness of CMP meetings, the DGHS trained Upazila and Union managers on health management information systems/digital health information systems (or DHIS2), data analysis, and data use for decision making and action. Then local authorities provided the training to all CHWs and their supervisors.

THE COMMUNITY SCORE CARD: INCREASING ACCOUNTABILITY AT THE COMMUNITY LEVEL

The DLL introduced the CSC, a bottom-up accountability and monitoring mechanism for continuous improvement of community health services. Still in effect, the CSC process engages the community, service providers, and the local government in a participatory forum that identifies issues and prepares an action plan that is consequently implemented, monitored, and evaluated. Using a CSC tool, community members and CHWs separately assess the CC services and document their perceptions, challenges, and opportunities. After the review, both groups come together in an interface meeting with local government officials where actors agree on an action plan for improving health services and a monitoring system to ensure agreed upon actions are carried out. CGs are responsible for following up and monitoring milestones on the action plan through their monthly meetings. Then the full process repeats for continuous quality improvement. Given that CC management structures—CGs, UHE&FP Standing Committees, and CHW supervisors—participate in the CSC facilitation process and regular CG meetings, the CSC process organically integrates into local health management systems.

To support the CSC process, CHW supervisors received training on effective supervision and monitoring. This training promoted more frequent and collaborative engagement with CHWs, the use of standard checklists and tools for review and discussion, and quality improvement. The project also facilitated joint supervision visits that brought together Union and Upazila managers from both the Health Services and Family Planning divisions.

Implementation of the CSC led to concrete identification of challenges for quality health services, the creation of action plans, and increased local government involvement and resource commitments. In the medium term, most action plans were implemented, leading to improved perceptions of service quality by clients and increased service use.[11]

COMMUNITY SCORECARD PROCESS AND TOOL

A meeting with the community is facilitated as part of the CSC process. Photo credit: Save the Children.

Interface meeting and action planning. Photo credit: Save the Children.

Common recommendations given at interface meetings held in Barisal's DLL:

- Recruitment of a cleaner and security guard for the CC with the support of local government and CG
- Strategic service plan for unused areas in the CC
- Initiatives to improve service providers' attitude, behavior and counseling skills
- Supervision of CHWs by first-line supervisor and CG
- Local government to make improvements and repairs to CCs
- Resource mobilization to help with repairs and purchase of essential medicines and supplies
- Activities to promote CC services

PHASE I: Planning and Preparation. In consultation with local authorities and stakeholders, a committee is formed and oriented to facilitate the score card process at the community level. The CSC facilitation committee includes members from various CC management and supervision structures: two CG members, two local government (UP) representatives, two CHW supervisors, and one NGO supervisor.

PHASE II: Conducting the Score Card with the Community. Using an input tracking matrix and the CSC tool, community members provide their perceptions and assessment on the CC. Four to six meetings with 10-15 participants are held per CC.

COMMUNITY SCORE CARD TOOL: Illustration of Community Score Card tool for community and provider assessments of the Community Clinic

INDICATOR	SCORE				Remarks	Total marks	%
	POOR	AVERAGE	GOOD	VERY GOOD			
Cleanliness							
Time management							
Providers' behavior							
Availability of medicines and services							
Service quality							
Clinic management							

PHASE III: Conducting the Score Card with Service Providers. Using the CSC tool, CHWs provide their assessment on the community clinic.

PHASE IV: Interface Meeting and Action Planning. Community members, CG and CSG members, CHWs, supervisors and managers, local government representatives, and other stakeholders participate in the meeting. CSC findings are shared, followed by a prioritization exercise and action plan development.

PHASE V: Action Plan Implementation and Monitoring and Evaluation (M&E). Action plan is implemented and monitored through CG/CSG regular activities.

Creating Platforms to Enable Dialogue and Consensus Building at All Levels

At the onset of the investment, the ICHW project worked in close collaboration with the MOHFW to create multi-stakeholder platforms at the national and local levels. These platforms provided oversight to project deliverables, facilitated sharing of program learnings, and enabled dialogue and consensus building between different government departments, civil society, and the private sector. With these platforms, the project sought to advance community health institutionalization by helping to address one of Bangladesh's main challenges for program governance and management: its fragmentation and limited coordination between stakeholders involved in the country's pluralistic community health system.

Stakeholder platforms aimed to improve coordination and collaboration by providing an inclusive and effective environment for partnerships that may not have been available otherwise. These platforms played a catalytic role by providing opportunities to engage in national-level dialogue on community health services and by strengthening collaboration with ministerial members responsible for policy reform. Greater collaboration helped expedite advocacy processes and increase the ability of stakeholders to influence policies and contribute at different stages of the policy development.[13]

STAKEHOLDER PLATFORM MEMBERSHIP

National Steering Committee: MOHFW, MOLGRDC, USAID, UNICEF, SCI.

National Stakeholder Forum: MOHFW, NIPORT, LGD, BRAC, UNICEF, USAID, WHO, UNFPA, SCI, NGO/INGOs.

District Coordination Committee: District and Upazila Health Services and FP managers, District government officials, NGO/INGO representatives, CSOs.

USING LEVERS TO CATALYZE COMMUNITY HEALTH INSTITUTIONALIZATION

Various tactics helped to increase the effectiveness of stakeholder platforms in catalyzing community health systems reform.

1. Leveraging the experience and partnerships that the local NGO partner—Save the Children—had built with national and local authorities, the civil society, NGOs, and development organizations over 15 years of working through multiple CHW project interventions in the country. The ability to partner with key players in the health sector and engage policy makers and other stakeholders with political influence was critical to the advocacy process and helped overcome the bureaucracy that often makes policy change lengthy and cumbersome.[13]
2. Working in partnership with key global players—such as UNICEF, USAID, WHO, and UNFPA—increased cohesion, synergies, and overall project leverage.[13] The ICHW project especially leveraged the bilateral partnerships of UNICEF and USAID in country. UNICEF's partnership with the MOHFW was a critical lever for the creation of a National Steering Committee on community health. Moreover, the ICHW project established a strong collaboration with two USAID-funded projects: MaMoni Health Systems Strengthening and MaMoni Maternal and Newborn Care Strengthening. This collaboration fostered bi-directional learning activities on local government engagement and capacity building for CHWs. Joint quarterly meetings between Save the Children, UNICEF, and USAID as well as joint field visits to the DLL in Barisal were also key to continuous coordination, collaboration, and project progress.
3. Employing the broader ICH platforms. Starting with the preparation of a country delegation to attend the Institutionalizing Community Health Conference (ICHC) in March 2017, the project leveraged momentum from participation in high level forums and partnerships with key global players to accelerate advocacy and policy reform. During ICHC 2017, Bangladesh's delegation, including seven members of the MOHFW, committed to institutionalizing

community health. They prepared a country action plan that brought national stakeholders together to discuss priority areas identified by the country delegation. Similarly, in preparation for the Second International Symposium on CHWs in November 2019, the development process for a National CHW Strategy accelerated and elevated commitment to the strategy and future directions for community healthcare in Bangladesh.

SETTING UP INCLUSIVE AND EFFECTIVE FORUMS FOR COORDINATION

The ICHW project convened three multi-stakeholder platforms.

1. A National Steering Committee (NSC) to provide policy and strategic guidance, provide project oversight, review and endorse best practices, and facilitate its incorporation into operational plans.
2. A National Stakeholder Forum (NSF) to provide technical guidance and inputs into the CHW strategy and policy processes.
3. A District Coordination Committee (DCC) with local government stakeholders to oversee and effectively implement learning agenda activities (Barisal DLL) at the local level.

The NSC was chaired by the Additional Secretary (Admin) & LD Human Resource Development (HRD),—the authority within the MOHFW responsible for policy development and implementing the Human Resource Development Operational Plan—which facilitated alignment of the CHW Strategy with Bangladesh's NHWS. The NSF was chaired by the LD CBHC, and the DCC by the Civil Surgeon of Barisal District.

The NSC and NSF convened key stakeholders in Bangladesh's community health system: national and local governments, major NGOs, development partners, professional associations, the private sector, and CSOs. Critically, government stakeholders included representatives from both the DGHS and DGFP, as well as LDs responsible for implementing operational plans involving community health services and health workforce development—CBHC, MNCAH, and HRD. The Local Government Division of the MOLGRDC was also convened given its responsibility of regulating local governments.

In April 2017, the ICHW project organized a National Stakeholders' Consultative Workshop on improving community health programs in Bangladesh. The workshop provided an overview of the ICHW project and shared key action points from the ICHC 2017 Conference. Stakeholders identified a scope of collaboration to build up consensus on the areas and process for harmonization of CHW cadres.

BUILDING PARTNERSHIP AND CONSENSUS THROUGH THE NEW STAKEHOLDER PLATFORMS

CUSTOMIZING A CHW DEFINITION FOR BANGLADESH

National stakeholders recognized that the lack of consensus over the definition of a CHW in Bangladesh hindered the effective application of existing national policies and strategies that broadly refer to CHWs. Annual ICHW project reports characterized the challenge in this way:

> *"The term CHW is broadly used for mixed groups of health workers among governmental and non-governmental organizations in Bangladesh." (ICHW Annual Report, Year 2)*

> *"Ambiguities among stakeholders to specifically define the CHW cadre in the context of Bangladesh makes it difficult to address structural and policy gaps, creates lack of strategic directions regarding optimal utilization of CHWs." (ICHW Annual Report, Year 3)*

CHW DEFINITION APPROVED BY THE MOHFW

A CHW is a permanent resident of a particular community, assigned by government/non-government organization, who provides promotive, preventive, limited curative care, rehabilitative, palliative and referral services in relation to maternal, neonatal, child and adolescent health, family planning, nutrition, communicable and non-communicable diseases to his/her community and shall be held accountable for the nonperformance of these services.

Thus, stakeholders prioritized the creation of a context-specific CHW definition for Bangladesh to eliminate ambiguity. Initially, during the second NSC, stakeholders prepared and discussed an adaptation of the existing WHO CHW definition for Bangladesh. Then, the ICHW project facilitated a series of national and district consultative workshops to gather feedback and build consensus on the definition. Last, the NSF gathered additional feedback and finalized the definition through a small technical committee. The definition received final endorsement from the NSC in September 2018.

The development of the context-specific CHW definition allowed stakeholders to collaborate and engage through new platforms, laying down the foundation for future efforts to influence national policies and systems:

> *"The ICHW project work received appreciation (from stakeholders) and ultimately provided the project with a greater opportunity to address other critical issues related to community health programs, and support from stakeholders in the facilitation of developing the National Strategy for CHWs." (ICHW Annual Report, Year 3)*

UPDATING CHWS' PROFILE AND DEVELOPING A HARMONIZED JOB DESCRIPTION

Stakeholders acknowledged that changes over time in Bangladesh's community health programs, as well as the country's evolving health sector landscape and emerging health needs, called for updating the profile of CHWs. Moreover, recognizing that the current community clinic strategy is heavily dependent on the effective work of CHWs, stakeholders concurred on the need to develop a standardized CHW JD in line with the Fourth National Health Sector Plan, health-related SDGs, and the current ESP.

In this context, the ICHW project facilitated the development of an updated CHW profile by leveraging experience from the different types of CHWs working in Barisal's DLL—whose roles varied widely in terms of activities and tasks, system support and gaps, contributions, and potential. Through local learning, a technical group from the DCC strengthened the existing profile of CHWs in Barisal and added new elements such as the remuneration of different CHW cadres and coordination mechanisms between CHWs.[14] In parallel, through the NSC and NSF, the project facilitated the development of a harmonized JD for CHWs, which the MOHFW endorsed for testing in Barisal's DLL. The updated CHW profile and harmonized JD were later disseminated and used as inputs for the National CHW Strategy.

DRIVING THE HEALTH POLICY AGENDA FORWARD

USING THE DLL AS A DEMONSTRATION SITE FOR POLICY LEARNINGS

Setting up Barisal's DLL in conjunction with the stakeholder platforms was a key strategy to drive forward the institutionalization of Bangladesh's community health system. Through the DLL, stakeholders could influence the learning agenda, test and refine interventions, document findings, and collect evidence to inform proposed policy and program innovation at the national level. District and national MOHFW authorities were closely involved through their participation in the DCC and visits to demonstration sites. Key stakeholders from government and non-government sectors (e.g., UNICEF, WHO, UNFPA, and BRAC) participated in the inauguration of the CC Centered Health Service Model, increasing visibility and political commitment.

During the ICH investment period, DLL learnings reinforced strategic recommendations, such as harmonizing the JD of CHWs, and informed the National CHW Strategy development process. At the close of the investment, the DLL had provided evidence on the effectiveness of several interventions to strengthen CHW program performance through the CC Centered Health Service Model. The DLL has also developed a body of products, tools, and guidelines to implement and scale the proposed interventions: a community engagement plan, a local government engagement strategy, harmonized and individual JD for CHWs, and a capacity development plan for CHWs.

DEVELOPING AND LAUNCHING A CHW STRATEGY

The NSC and NSF were critical platforms for the development of the CHW Strategy. Previous joint learning and dialogue on gaps, priorities, and solutions laid the foundation for the strategy development process. Then, these bodies worked with the MOHFW to incorporate proposed recommendations into existing policies and guidelines.[14]

The CHW Strategy development process was initiated by the ICHW project in close collaboration with the MOHFW in late 2018. The CBHC unit of the DGHS led and facilitated the overall process, while the ICHW project provided technical assistance. The Community Health Systems Reform Cycle (detailed in the preface) provides a useful framework to describe the strategy development process.

PROBLEM PRIORITIZATION AND COALITION BUILDING

In January 2019, the CBHC unit convened an initial meeting of the NSF, where partners developed a draft position paper recognizing emerging challenges for CHWs in Bangladesh and the need to focus on the development of a CHW Strategy as an upcoming priority for UHC. (See Appendix 4 for more detail.) The position paper also proposed the formation of three technical working groups (TWGs) on agreed domains: 1) selection, education, and certification, 2) management, supervision, and integration, and 3) support by health system and communities. All TWGs had a diverse representation of members from different stakeholder groups, including DGHS and DGFP divisions of MOHFW.

In February 2019, the NSC approved the position paper and roadmap for developing the CHW Strategy as a supplementary document to Bangladesh's NHWS and considering the WHO guideline throughout the process.

SOLUTION GATHERING AND ASSESSMENT

From March to April 2019, working groups reviewed existing policies and evidence, and drafted content. A consultant compiled input from the TWGs into a draft strategy and incorporated feedback from community health programing experts of the country. Then six consultative workshops—five at the divisional level and one at the national level—were held through June 2019 to share the draft strategy and gather additional feedback.

POLICY AND PROGRAM DESIGN

During July and August 2019, the NSF reviewed the draft strategy after getting inputs from the consultative workshops, and the consultant made a final compilation. In September 2019, the NSC approved the National CHW Strategy and, a month later, the MOHFW endorsed it. The Bangladesh National Strategy for Community Health Workers (2019-2030) was launched during the 2nd International Symposium for CHWs in Dhaka, Bangladesh, in November 2019.

Broader Reform Milestones During the ICH Period: The Community Clinic Trust Act—2018

In 2018, the GOB enacted the Community Clinic Health Support Trust Act which created a Community Clinic Trust (CC Trust) to absorb overall management and governance of the CBHC program upon conclusion of the CBHC revitalization initiative.

The creation of the CC Trust represents a milestone in Bangladesh's Community Health Systems Reform Cycle and a step towards greater integration as

it brings the management of community-based healthcare services under one governing body—a Board of Trustees with senior members from various government ministries and MOHFW departments involved in the CBHC Program[iv]—providing an institutionalized and consolidated platform for coordination across the health sector. In addition to its Board of Trustees, the CC Trust has an Advisory Council headed by the Prime Minister and includes the Minister of Health and Family Welfare, the Minister of Finance, and the Minister of Planning, signaling the highest political commitment at the national level.

As the managing and governing body of the CBHC Program, the CC Trust through its Board of Trustees is responsible for the overall management and maintenance of community clinics and associated activities: mobilizing CGs and CSGs; assisting them in running the community clinics; ensuring community participation and social support in primary healthcare activities and delivery; collecting and using funds; establishing an effective integration between community, Union, and Upazila health services; and involving social organizations, NGOs, private sector individuals, and local government organizations in the delivery of integrated primary healthcare.[15]

The CC Trust also represents a step towards an integrated and sustainable financing mechanism for the CBHC Program as it sets a pooled fund to be used specifically for the CBHC program and the CC Trust operations. The Trust collects, consolidates, and uses a variety of funds including one-time and annual government grants, development partner grants, donations from local individuals or authorities, and voluntary financial support from public and private organizations.

So far, the CC Trust has absorbed all employees of the CBHC revitalization initiative, including CHCPs, who are now under the government revenue sector with a permanent job and ability to obtain benefits as regular government employees. Furthermore, employees operating under the organizational structure of the Trust and the administrative structure of the Health Care Department with CC management responsibilities now respond to the Trust's Managing Director. This structure helps to strengthen integration of the CBHC program management under the Trust.

[iv] The 14-member Board of Trustees include the two Secretaries and Director Generals of the Health Services and Family Planning divisions of the MOHFW, Secretaries from the Finance and Planning Departments, and other members from the civil society and private sectors. Members are appointed for three years and are headed by a Managing Director, an Additional Secretary-level official within the MOHFW.

Opportunities and Next Steps for Bangladesh

The ICH Investment: Recapping Outcomes

The ICHW project significantly advanced the goal of optimizing CHW program performance in Bangladesh by addressing major barriers and strengthening existing national policies, systems, and implementation mechanisms. The ICH partnership—through the work of the ICHW project—also had a multiplier effect by contributing to catalyze the Community Health Systems Reform Cycle process in various ways, overcoming country barriers to community health institutionalization.

At the DLL, the project developed approaches to harmonize CHWs, strengthen community engagement, and increase local government support. They then tested these approaches under a Community Clinic Centered Health Service model and used the learnings and evidence to contribute to the development of a National CHW Strategy.

The project also convened multi-stakeholder platforms at the national and local levels to facilitate coordination in the country's pluralistic health sector environment, and enable dialogue and consensus building that contributed to advance the policy dialogue on community health. The use of these platforms critically contributed to accelerate the development of the National CHW Strategy.

With these strategies and approaches, the investment paved a way forward for strengthening, coordination, and harmonization at all levels within the existing structures. The project provided evidence on key tactics at the national and local levels that can strengthen program management and governance in a context of fragmentation, allowing the reform cycle to move forward.

Project learnings, products, and platforms paved the way for future reform cycle stages and further institutionalization. Learnings from the DLL—such as the development of a harmonized JD, capacity building plan for CHWs, and protocol for implementation of the CC-centered model and its innovations—laid the groundwork for future solution gathering and assessment stages. The creation of the NSF and NSC as permanent platforms already proved their ability and utility to identify priority areas for reform, gather and assess solutions, and redesign policies.

The major outcome of the ICHW project was the development of the National CHW Strategy in line with the National Health Workforce Strategy 2015. The Bangladesh National Strategy for CHWs denotes a wider understanding, structure, framework, and strategic direction for CHWs in the next ten years.[13]

Future Directions and Opportunities for Contribution to Ongoing Agenda

The next decade will be critical to cement Bangladesh's community-based healthcare as the cornerstone of its primary healthcare system and achieve SDGs and UHC by 2030. Building on previous learnings and achievements, and under the oversight of the new CC Trust, the community health system faces opportunities to further strengthen its institutionalization with a view of increasing access to quality healthcare for the entire population.

The National CHW Strategy in the National Health Workforce Strategy provides strategic directions to strengthen the capacity and performance of CHWs. Next steps include further developing key definitions and components of the strategy, costing out and operationalizing the strategy, and developing an implementation plan and rollout

guidelines inclusive of dissemination strategies and a training and capacity building plan for CHWs and local managers.

Country stakeholders can leverage outputs and tools developed through the ICHW project to keep advancing the community health systems institutionalization agenda. For example, they can: 1) Leverage the created stakeholder forums as platforms to consolidate the initial stages of a new reform cycle—share learnings, build coalitions, prioritize problems, gather and develop solutions—and, 2) Capitalize on existing learning and evidence on harmonization, community engagement, and local governance to further develop programmatic design and build readiness.

FURTHER DEVELOP KEY DEFINITIONS AND COMPONENTS OF THE STRATEGY

In March 2020, the CHW strategy was formally presented to the MOHFW. Three working groups were formed to further develop the three major domains of the strategy. Representatives from government directorates, major development partners, and NGOs agreed to participate in developing a costed action plan. Although the NSC requested that this process start immediately and take no longer than two months, the COVID-19 pandemic has delayed this activity.[12]

DEFINE THE CHW COVERAGE APPROACH AND PROJECTED NUMBER OF HEALTH WORKERS TO BE DEPLOYED

One area of the strategy that needs further definition is the ward/population coverage approach for CCs and the number of CHWs to be deployed based on the chosen approach and the interaction between different CHW cadres under the chosen approach. The strategy proposes two alternative scenarios based on ward coverage: either one CC for every three wards (current scenario) or one CC per ward. Given that CHCP are based at the CC level, the total number of CHWs—ranging between 18,000 and 41,000 CHCP—will depend on the chosen approach.

Critically, the definition of coverage approach and total number of projected CHWs to be deployed should consider NGO plans in community health programming and the evolving health sector landscape. Recent changes in BRAC's health program operation—involving a shift to a social enterprise approach and a revamping of their Shastya Kormis as Community Health Associates[16] with a greater focus in NCDs—has reduced the size of its community health program intervention throughout the country. Given the size of BRAC's participation in the community health sector, the MOHFW should design a coverage approach of its own CHWs, taking these changes into consideration.

Additionally, the coverage approach for CHWs and CCs should take into account that the MOHFW recently introduced two programs with auxiliary CHW cadres: Multi-Purpose Health Volunteers (MPHVs), who are engaged by the DGHS as auxiliary volunteers within the catchment area of CCs (five MPHVs per CC), receiving performance based incentives and monitored by CHCPs; and Paid Peer Volunteers (PPVs), who are engaged by the DGFP on a ward basis to cover gaps due to the shortage of FWAs as an interim arrangement. The DGHS has already recruited MPHVs in over a hundred Upazilas and it is expected that the cadre will be fully scaled in all the 492 Upazilas by 2022.

DEFINE INDIVIDUAL JD AND COMPLEMENTARY WORK ALLOCATION FOR ALL CHW CADRES

Another area of the strategy that will require further development is the definition of individual JDs and complementary work allocation for all CHW cadres. The harmonized JD is an important milestone for strengthening coordination of CHWs and is built considering that each CHW cadre "will perform their activities according to their individual JDs from relevant directorates".[5] To ensure an appropriate scope and skills mix of CHWs providing PHC services at the CC, the MOHFW should develop additional guidelines to tailor individual JDs for all cadres, and align these with skills requirements and capacity building plans.

COST OUT AND OPERATIONALIZE THE STRATEGY

The MOHFW and its partners have agreed on the need to cost out the strategy and there are plans

to hire a technical expert for this purpose, however the COVID-19 pandemic has delayed this activity.[12] Additionally, staff turnover at the MOHFW—including a recent change in the Additional Secretary (Admin) & LD HRD appointee who had chaired the NSC and was acquainted with the CHW Strategy development process—has furthered delayed strategy operationalization activities. Once the process resumes, the multi-stakeholder platforms under the leadership of the HRD unit of the MOHFW can play a strong role in convening key health sector stakeholders and community health experts to operationalize and implement the strategy. Multi-sectoral involvement focused on strengthening the CBHC program should closely involve and facilitate coordination among the MOHFW, the MOLGRDC, and the CC Trust to ensure strategic alignment and proper allocation of funds for implementation activities, in addition to the regular operation of the CBHC program.

The MOHFW and its partners should also target opportunities to operationalize the strategy through the CBHC Operational Plan. A key priority is the development of the costed action plan in anticipation of the next MOHFW Sector Program—expected to start in 2022—to ensure the integration and operationalization of the CHW Strategy. The 4th HPNSP (2017-2022) revision process held in 2020 already developed a priority action plan for the CBHC OP that provides opportunities for integrating the experience and learning from the ICHW project. Identified priorities and milestones include:

- Redefine job description by December 2020 and initiate capacity building activities
- Involve volunteers based on vacant fieldworker positions with uniform criteria and package for all directorates and OPs
- Develop strategic partnerships with NGOs, CBOs, LGIs, and the community at each tier of PHC system with supportive TOR aligned with the strategy by 2021
- Establish a recruitment and deployment action plan based on existing projections, which prioritize the PHC workforce and support delivery of the ESP[v]

The CBHC program should also keep strengthening integration of the CHW Strategy into the broader health policy and financing agenda and make additional efforts to further integrate with the Bangladesh National Health Workforce Strategy. In these operationalization and integration processes, the MOHFW should ensure alignment across the CHW Strategy, the CBHC Operational Plan, and broader national health workforce planning. For example, the current CBHC Operational Plan covers a target of 14,890 CHCP, while the CHW Strategy sets a new target of 18,000-41,000 CHCPs and 100,000-124,000 total CHWs (including FWAs and HAs), a significant increase with respect to current targets and CHWs deployed. Additionally, the target number of MPHVs and PPVs should also align with CHW targets in the CHW Strategy. Similarly, community and local government engagement plans need to be further developed and mainstreamed into a national sector monitoring and evaluation plan to make them operational and institutional.

Finally, given historically institutionalized fragmentation of the MOHFW between the DGFP and DGHS, Bangladesh should especially focus on continuous improvement of governance and management of the CBHC program and the health sector in general. Under the current reform cycle, country stakeholders can leverage the creation of the CC Trust to further improve integration and management of the CBHC program. All senior MOHFW officials responsible for the CBHC program—including the DGFP and DGHS Directors—are part of the CC Board of Trustees. The CC Board is headed by a senior level Managing Director. This configuration could play a key role in aligning incentives and reaching consensus because it brings together key health sector stakeholders under one governing body and lead. In turn, this could help catalyze next steps in the community health systems reform cycle.

[v] Activity supported by USAID with focus on reducing existing vacancies in public facilities by June 2021.

DEVELOP AN IMPLEMENTATION PLAN AND ROLLOUT GUIDELINES

To implement the strategy, the GOB will have to develop training packages and a capacity development plan for CHWs and local managers. They should encompass the processes of CHW harmonization and team building, and community and local government engagement support processes. Stakeholders in Bangladesh can leverage detailed implementation guidelines developed at Barisal's DLL:

- Capacity development plan, including contents for skill development, mechanisms of periodic conduction of trainings, district implementation plans, and supervision and monitoring plans
- Team training model for CHWs coordination developed by NIPORT
- Harmonized job aids and orientation materials covering UP responsibilities for CC support
- Approach to formulating context-specific harmonized JDs for CHWs, including individual JDs that complement the harmonized JD
- Protocol for implementation of the CC model, reformation, and activation of CGs and CSGs, the Community Score Card, and Community Micro-planning meetings

A "District by District" implementation approach can expand activities tested within Barisal's DLL to larger geographic areas to refine and further institutionalize before national scale up. Documented findings from the CC centered model in Barisal's DLL and any other potential areas should also be disseminated as part of an advocacy plan with stakeholders and policy makers to inform further program design and readiness. Finally, the CHW Strategy and associated plans, guidelines, and documents will need to be disseminated widely.

In Conclusion

Over the last five years, Bangladesh has advanced the goal of institutionalizing community health and optimizing CHW program performance by addressing governance and management gaps in its Community Based Health Care program and by strengthening existing national policies, systems, and implementation mechanisms. The ICH investment contributed to these goals by testing program optimization approaches at the subnational level—in Barisal's District Learning Laboratory—and bringing learnings and evidence to inclusive local and national stakeholder platforms—a National Stakeholder Forum and Committee and a District Coordination Committee. These steps served to enable dialogue, consensus building, and coordination, thus facilitating and accelerating policy development in a pluralistic environment. The main outputs developed through these activities were 1) a National CHW Strategy, providing strategic directions to strengthen CHW performance and capacity; and 2) a series of tested protocols, guidelines, and tools for strengthening CHW harmonization and coordination, and community and local government engagement and support.

Building on previous learnings and achievements, the community health system in Bangladesh faces opportunities to further strengthen its institutionalization with a view of increasing access to quality healthcare for its entire population. Opportunities and next steps include:

- Further developing key definitions and components of the National CHW Strategy,
- Costing out and operationalizing the strategy,
- Developing an implementation plan and rollout guidelines that include dissemination strategies, and a training and capacity building plan for CHWs and local managers

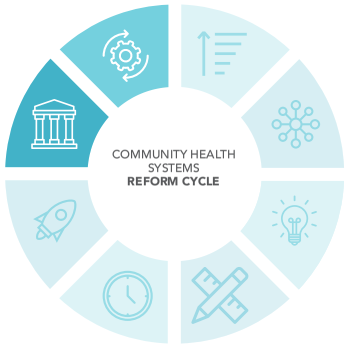
Tools developed through the ICH investment—such as harmonized and individual JDs for CHWs, training and capacity building plans, community and local government engagement plans, Community Score Card tool, and Community Micro-planning meetings—can be used in wider geographic areas. Through a "District by District" implementation approach, these tools can be leveraged for program design and readiness—leading to further strategy definitions and implementation plans. Stakeholder forums convened through the ICHW project can also be leveraged to play a strong role in building strategic partnerships and coordination across the health sector. These forums can help accelerate program design and readiness processes, and develop a costed action plan that can be incorporated into the next MOHFW Sector Program and CBHC Operational Plan in 2022.

BANGLADESH'S COMMUNITY HEALTH SYSTEM DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic has disrupted the delivery of and reduced equitable access to essential health services, including routine maternal and child health services, family planning, and immunization programs. The MOHFW has prioritized maintaining continuity of essential health services by developing COVID-19 context-specific national MNCH and immunization guidelines for frontline workers, building national capacity on WASH/IPC, developing logistics and supply chain management protocols (to ensure that frontline workers have sufficient and timely access to personal protective equipment), and strengthening laboratory testing capacity. The MOHFW has also developed communications, including posters and social media campaigns to raise awareness of preventive behaviors and help address misconceptions around COVID-19. CHWs received PPE and logistics support from their respective directorates to continue their essential service delivery within the static clinics and satellite centers.

Due to the COVID-19 pandemic, activities related to the costing and operationalization of the National CHW Strategy have been postponed. After the finalization of the CHW Strategy, the Additional Secretary (Admin) & LD HRD from the MOHFW—who had chaired the NSC—asked for support from donors in convening three key working groups. These groups would report to the NSC and develop a comprehensive action plan, including a costing and financial analysis component. Initial discussions were held to determine who should be included in the working groups, and the need for more and deeper technical discussions regarding the Urban Health and Private Sector components was acknowledged. However, these discussions stalled due to the pandemic and staff turnover at the MOHFW and are yet to be resumed.

INSTITUTIONALIZATION CHALLENGES



Institutional fragmentation across the health system

- Insufficient coordination between cadres and managing structures
- Prioritization of vertical program needs over Community Clinic

Suboptimal local governance, management, and community engagement

- Unawareness and poor clarity of roles and responsibilities
- Lack of mechanisms for periodic engagement and monitoring

Limited incentives and mechanisms for health sector coordination

- Vertical operational plans and structures
- Spheres of political and economic influence reinforced for decades

STRATEGIC ACTIVITIES ICH INVESTMENT

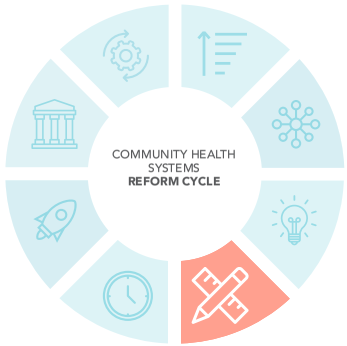
District Learning Laboratory

- Learning and refinement to optimize program performance
- Test innovations under Community Clinic model
- Demonstration site for policy learnings

National and local stakeholder forums

- Inclusive convening and coordination
- Enable dialogue and consensus building
- Pipeline for learning and policy reform
- Leverage existing experience and partnerships

OUTPUTS & TOOLS DEVELOPED



Harmonized job description for CHWs

- Harmonized JDs
- Guidelines for individual JDs
- Capacity development plan
- Team training model for CHW coordination

Protocol for implementation of CC model

- Activation of local governance and community structures
- Community Score Card tool
- Community Micro Planning meetings

National CHW strategy

Strategic directions to strengthen the performance and capacity of CHWs

OPPORTUNITIES & NEXT STEPS

Leverage NSC, NSF, and CC Trust to catalyze processes and ensure strategic alignment

Further develop key definitions and components of the CHW strategy

- Incorporate guidelines to elaborate individual JDs
- Define CC/CHW coverage approach and projected numbers considering government, NGO, and volunteer cadres.*

Cost out and operationalize the strategy

- Develop a costed action plan and incorporate into the next Sector Program and CBHC OP (2022).*
- Develop strategic partnerships with NGOs, CBOs, LGIs and communities in alignment to the strategy.*
- Develop a recruitment and deployment plan against health worker projections.*
- Mainstream community and local government engagement plans into a national M&E plan.

Develop implementation plan and rollout guidelines

- Develop a training and capacity building plan* for CHWs and local managers
- Expand CHW harmonization to larger geographic areas
- Disseminate the CHW Strategy

*Identified as priorities during the mid-term review of the 4th HPNSP.

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Appendices

APPENDIX 1: COMMUNITY HEALTH WORKER CADRES IN BANGLADESH

Government CHWs have diverse scopes of work and many have been involved with pioneering innovations that have subsequently been scaled up. Main CHW cadres include:

- Family Welfare Assistants (FWAs), who provide community-based FP services under the DGFP
- Health Assistants (HAs), who provide immunization and other PHC services under the DGHS
- Community Health Care Providers (CHCPs), who provide a range of preventive and primary curative care at CCs.

The MOHFW also recently introduced two programs with auxiliary CHW cadres:

- Multi-Purpose Health Volunteer (MPHV), who are engaged by the DGHS as auxiliary volunteers within the catchment area of each CCs.
- Paid Peer Volunteers (PPV), who are engaged by the DGFP on a ward basis to cover gaps due to the shortage of FWAs as an interim arrangement

Profiles of NGO-supported CHWs vary widely, ranging from paid full-time workers (e.g. Shasthya Kormi of BRAC) to volunteers who sell health commodities (e.g. Shasthya Shebika of BRAC), to NGO-supported private Community Skilled Birth Attendants (pCSBAs), and depot holders and volunteers who receive no monetary benefits (e.g., Community Volunteers of the MaMoni project).

APPENDIX 2: UPAZILA HEALTH SYSTEM

The Upazila Health System comprises:

- Domiciliary services
- Services through outreach and satellite clinics
- Services through fixed facilities at the ward, union, and Upazila levels.

The CC, at the ward level, is the lowest level fixed health facility of the Upazila Health System and is operated by the CBHC program.

At the Union level, Health and Family Welfare Centres (UH&FWCs) and union subcenters and rural dispensaries operate under the DGHS, with some UH&FWCs operating under the DGFP.

At the Upazila level, the Upazila Health Complex is the overall coordinator of the Upazila Health System

APPENDIX 3: IMPORTANT HEALTH SECTOR POLICIES AND STRATEGIES

- National Health Policy 2011 and National Nutrition Policy 2015
- Health, Nutrition and Population Strategy of the 7th Five Year Plan
- 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 - CBHC Operational Plan
- Healthcare Financing Strategy 2012-2032
- Bangladesh Health Workforce Strategy 2016–2021

APPENDIX 4: EXTRACT FROM NSF POSITION PAPER ON CHW STRATEGY - EMERGING CHALLENGES FOR CHWS IN BANGLADESH

"Historically in public sector of Bangladesh, CHWs were employed with a certain task, which evolved over years with substantial additions of new tasks. On the other hand, a number of CHWs involved in community health care from NGOs/Private sector where the coordination/collaboration with government system is absent in major cases. The below issues are the emerging challenges for a community health workforce to fit for purpose:

- *Principles for harmonization in CHWs' job*
- *Equitable allocation of CHWs*
- *HR planning (CHW needs—projections for next ten years)*
- *Capacity building*
- *Geographic focus—differential program approach*
- *Community engagement approach and plan*
- *Local government support plan*
- *Government-NGO coordination and competency approaches*
- *Use of technology*
- *Reporting and accountability arrangement*
- *Monitoring and supervision support plans*
- *Balance of male and female CHWs"*